

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

6231

1. PLACE OF DEATH

County HarfordCity or town Harford
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 mo. 28 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harford
(If outside city or town limits, write RURAL and give nearest town)Street No. 516 Freedom Alley
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Betty Jean Collins

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Negro

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 22, 19456.(c) If alive, give age 3 years

8. AGE:

Years

Months

Days

If less than one day

328

hrs.

min.

9. Birthplace

Harford, Md.
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

MOTHER

12. Name John H. Collins13. Birthplace Maryland14. Maiden name Pauline Robinson15. Birthplace Maryland

16. Informant

John H. Collins (father)

Address

516 Freedom Alley, Harford, Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

6/21/48
(month) (day) (year)

Cemetery or crematory

St. James

Location

Harford, Md.

18. Funeral director

Pennington & Son

Address

Harford, Md.

19. Date rec'd by registrar

June 21

19

48G. L. Lewis M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20, 1948 19 at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19 toand that I last saw him alive on 19 to

Immediate cause of death

Pneumonia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

6/20/48

RECEIVED

JUN 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

6232

CERTIFICATE OF DEATH

Reg. Dist. No.

185-

1. PLACE OF DEATH:

County MARYLAND
 City or town HAVRE DE GRACE
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 Hrs.
 Hospital, institution, or street address where death occurred:
MARYLAND MEMORIAL HOSPITAL
 How long in hospital or institution? 15 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil
 City or town CHARLESTOWN
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rural, Carpenters Point
 (If rural, give LOCATION)
 2. (a) If veteran, name war ✓

3. (a) FULL NAME

ALBERT COSLETT

3. (b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced SINGLE
 6. (b) Name of husband or wife _____
 7. Birth date of deceased (mo., day, yr.) July 28, 1883 6. (c) If alive, give age _____ years
 8. AGE: Years 64 Months 10 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Retired Railroad man
 11. Industry or business _____

FATHER 12. Name Joseph J. Coslett
 13. Birthplace Lancaster Co., Pa.
 MOTHER 14. Maiden name Anna E. Alexander
 15. Birthplace Baltimore, Md.

16. Informant E. Roy Coslett
 Address Charlestown, Md. Rural
 17. Removal & Burial Date thereof 6-10-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Lawn Croft Cemetery
 Location Philadelphia, Pa.

18. Funeral director Lee A. Patterson & Son
 Address Box 157, Perryville, Maryland

19. June 10 19 48 G. L. Lewis M.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 June 19 48 at 10:30 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 46 to June 19 48
 and that I last saw him alive on 9 June 19 48

Immediate cause of death Diabetic Coma DURATION _____

Due to Diabetes Mellitus

Due to _____

Other conditions Cerebral Thrombosis
Atherosclerosis
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE M. H. Sadowsky M. D. or other _____
Perryville Address _____ Date signed 9 June 48

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JUN 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6233

Reg. Diat. No. 185-

1. PLACE OF DEATH:

County Harford
 City or town Havre de Grace
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial

How long in hospital or institution?

13 days

3. (a) FULL NAME

Dolly M. Cromwell

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

William E. Cromwell

7. Birth date of

deceased (mo., day, yr.)

Oct. 19, 1880

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

if less than one day

hrs.

min.

67 7 19

9. Birthplace

Maryland

(Town, county and state)

10. Usual occupation

Domestic Servant

11. Industry or business

William S. Lee

12. Name

Maryland

13. Birthplace

Unknown

14. Maiden name

15. Birthplace

William E. Cromwell

16. Informant

Abingdon Md

Address

Burial June 11, 1948

(Burial, cremation, or other) (Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

John Wesley

Location

Abingdon Maryland

17. Funeral director

Howard K. McKenna & Son

Address

Abingdon Maryland

June 11, 1948

18. (Date rec'd by registrar)

G. L. Lewis Jr.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Abingdon
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 JUNE 48 at 1:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

26 MAY 48 to 8 JUNE 48and that I last saw her alive on 5 JUNE 1948

Immediate cause of death

CARDIO-RESPIRATORY FAILURE

DURATION

AND IN ANITATIONDue to GENERALIZED CEREBRALARTERIO-SCLEROSIS

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. ARTERIO-SCLEROSISAutopsy results ARTERIO-SCLEROSIS

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Signature AB Norman MDAddress Harford Mem. Hosp. Date signed 6-8-48

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JUN 14 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County Harford
 City or town Harre De Grace
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months
 Hospital, institution, or street address where death occurred:
801 Lafayette Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland, County Cecil
 City or town Rising Sun
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Bertha M. Garvin

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Marion A. Garvin
 6.(c) If alive, give age 69 years
 7. Birth date of deceased (mo., day, yr.) 9-12-1883

8. AGE: Years 64 Months 8 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Rising Sun, Cecil County, Maryland
 (Town, county, and state)

10. Usual occupation housewife

11. Industry or business _____

12. Name Samuel J. Morrison

13. Birthplace Harford County

14. Maiden name Elizabeth J. Holden

15. Birthplace Harford County

16. Informant Samuel M. White

Address Rising Sun Maryland

17. Burial Date thereof June 13, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brockview

Location Rising Sun Md.

18. Funeral director J. E. Tyson

Address Rising Sun Md.

19. June 27 1948 A. L. Lewis M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1948 at 11:30 A.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from June 27, 1948 to June 27, 1948

and that I last saw him alive on June 27, 1948

Immediate cause of death _____ DURATION _____

Carcinoma Stomach
Gall Bladder, Colon

Due to General Carcinomatous

Due to _____

Other conditions Cardiac

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

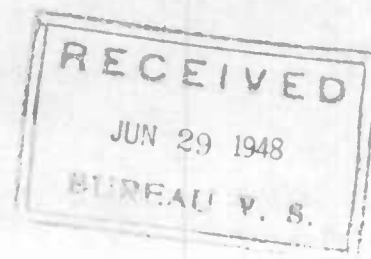
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Charles J. Foley M.D. M. D. or other _____

Address Rising Sun Md. Date signed 6/27/48



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6235

Reg. Dist. No. 181

1. PLACE OF DEATH:

County Harford
 City or town Rural Aberdeen Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Harford
 City or town Rural Aberdeen Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Harrison Morton Grieninge

3. (b) Social Security Number

213-16-9812

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Beth Elizabeth Grieninge

7. Birth date of deceased (mo., day, yr.)

June 23, 1889

8. AGE:

Years 59 Months 11 Days 21
 If less than one day _____ hrs. _____ min.

9. Birthplace

Penn.
(Town, county and state)

10. Usual occupation

Carpenter

11. Industry or business

John Grieninge

12. Name

Pa.

13. Birthplace

Margaret Bacon

14. Maiden name

Pa.

15. Birthplace

Ms. Bertha E. Grieninge

16. Informant

Aberdeen Md. R.D. #1

17. Burial

June 17, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Angel Hill Cem.

Location

David de Grace Md.

18. Funeral director

R. Madison Mitchell

Address

David de Grace, Md.

19. June 15, 1948

Nellie Z. Riley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1948 at 7:05 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27, 1948 to June 14, 1948
 and that I last saw him alive on June 14, 1948

Immediate cause of death

Adenocarcinoma of
large intestine with
metastases

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

John L. Lauer, M.D.
Aberdeen Date signed 6/15/48
 M. D. or other

RECEIVED

JUN 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, IN UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6236

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Harford
 City or town..... Rocks, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 6 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Harford
 City or town..... Rocks, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Old Salem Church Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

GEORGE H. HOHMAN

3. (b) Social Security Number

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... married
 6.(b) Name of husband or wife..... Marie C.
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... Oct. 17th, 1886
 8. AGE: Years..... 61 Months..... 8 Days..... 3 If less than one day..... hrs. min.

9. Birthplace..... Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation..... Farmer
 11. Industry or business.....

FATHER
 12. Name..... George A. Hohman
 13. Birthplace..... Baltimore, Md.
 MOTHER
 14. Maiden name..... Margaret Pohlman
 15. Birthplace..... Baltimore, Md.

16. Informant..... Mrs. George H. Hohman
 Address..... Old Salem Church Rd., Rocks, Md.
 17. burial Date thereof..... 6/23/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Parkwood
 Location..... Baltimore, Md.

18. Funeral director..... Lassala Funeral Home
 Address..... 7401 Belair Rd.

19. June 21 19 48 a. w. H. H. H.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 20th, 19 48 at 3:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 19 48 to June 20, 48
 and that I last saw him alive on June 14 19 48

Immediate cause of death..... Renal failure & uremia
& general metabolic debility
 Due to.....
Carcinoma, primary in Rectum
 Due to.....
& metastases to prostate & liver
 Other conditions.....

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations..... Carcinoma of Rectum
 Date of op..... March 48

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE..... James H. H. H. M. D. or other
 Address..... James H. H. H. Date signed..... 6-26-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The doctor's age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

6237

185-

1. PLACE OF DEATH:

County Harford
 City or town Harre de Grace, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

30 MIN.

Hospital, institution, or street address where death occurred:

HARFORD MEMORIAL HOSP, Harre de Grace

How long in hospital or institution?

30 MIN.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford
 City or town Harre de Grace
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 403 S. Stokes Street
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

JAMES JACKSON

3. (b) Social Security Number

218-05-1478

4. Sex

M.

5. Color or race

O.

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife

NONE

7. Birth date of deceased (mo., day, yr.)

About 1/31/1902

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

46419

hrs.

min.

9. Birthplace

Los Angeles Calif.
(City, county, and state)

10. Usual occupation

Retiree

11. Industry or business

FATHER
 MOTHER

12. Name

No Record

13. Birthplace

No Record

14. Maiden name

No Record

15. Birthplace

No Record

16. Informant

Mrs Helen J Hawkins

Address

564 Girard St

17.

(Burial, cremation, or removal of which?)

Date thereof

June 24 48
(month) (day) (year)

Cemetery or crematory

Skinner's Cemetery

Location

Harre de Grace, Md.

18. Funeral director

Elmer E. Bullock

Address

556 Lewis St. Harre de Grace, Md.

19.

June 22

19

48G. L. Lewis M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

19 June

19

48 at 4:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 June

19

48

at

19 June

19

48

and that I last saw him alive on

19 June

19

48

at

19 June

19

Immediate cause of death

CEREBRAL HEMORRHAGE

DURATION

Due to

HYPERTENSION

Due to

Other conditions

POSSIBLE DIABETES
AND CHRONIC NEPHRITIS
(Include pregnancy within 3 months of death)

Major findings of operations

- NONE

Date of op.

Autopsy results

- NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. B. Morment M.D.

M. D. or other

Address

Harre de Grace

Date signed

19 June 48

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JUN 23 1948

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County Harford CountyCity or town Harre de Grace, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs.

Hospital, institution, or street address where death occurred:

Yacht Basin

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Abertdeen

(If outside city or town limits, write RURAL and give nearest town)

Street No. Edmund St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

WALTER A KELL, Jr.

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

B. (b) Name of husband or wife

Dec. 15, 1932

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) Dec. 15, 1932

8. AGE:

Years

Months

Days

If less than one day

15629

hrs.

min.

9. Birthplace Harre de Grace, Md.

(Town, county, and state)

10. Usual occupation School Boy

11. Industry or business

FATHER

12. Name

Walter F. Kell, Sr.

13. Birthplace

Perryman, Md.

MOTHER

14. Maiden name

Lillian B. Williams

15. Birthplace

Perryman, Md.

16. Informant

Walter F. Kell, Jr.

Address

Abertdeen, Md.

17.

Burial

Date thereof

June 17 48

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Union M. E. Cemetery

Location

Syran Creek

18. Funeral director

Elmer E. Bullard

Address

556 Lewis St. Harre de Grace, Md.

19.

June 17

19

48A. L. Lewis M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1948 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1948 to 1948and that I last saw h. alive on 1948

Immediate cause of death

DURATION

Drowning - Accidental

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of June 14, 1948Where did injury occur Harre de Grace Harford Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) yacht BasinMeans of Injury Dive into deep water Injured at work? No23. SIGNATURE J. H. Ramsey M.D.Address Abertdeen, Md. Date signed June 17, 1948

RECEIVED

JUN 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford
City or town Barlingford
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 80
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Harford
City or town Barlingford
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION) no
2. (a) If veteran, name war _____

3. (a) FULL NAME

Margaret Wilson Kirk

3. (b) Social Security Number

no

4. Sex Female 5. Color or race White 6. (d) Single, married, widowed, or divorced Widow
6. (b) Name of husband or wife W. B. Kirk
7. Birth date of deceased (mo., day, yr.) May 1, 1868
8. AGE: 80 Years 1 Months 11 Days hrs. min.

9. Birthplace Harford Co., Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business at home

12. Name David E. Wilson

13. Birthplace Harford Co., Md.

14. Maiden name Mary Wilson

15. Birthplace Harford Co., Md.

16. Informant Walter W. Kirk

Address Barlingford Md.

17. Burial Date thereof June 12, 1948
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Barlingford Cem.

Location Harford Co., Md.

18. Funeral director H. S. Bailey

Address Barlingford Md.

19. June 11, 1948 C. V. Kirk
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1948 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to June 11 1948

and that I last saw her alive on June 12 1948

Immediate cause of death Cerebral tumor legs 6 days

Other conditions ✓

Major findings of operations ✓

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of June 11, 1948

Where did injury occur? Barlingford Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ✓

Means of injury ✓ Injured at work?

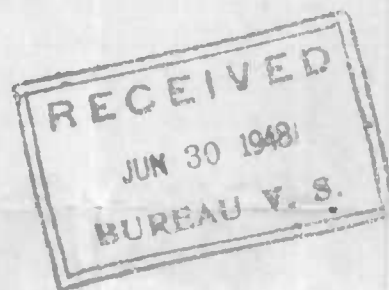
23. SIGNATURE W. E. Gallion M. D. or other

Address Barlingford Md. Date signed 6-11-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1700 6240 181

1. PLACE OF DEATH:

County HarfordCity or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

CEARA

3. (b) Social Security Number

212-26-6154

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

May 10, 1903

8. AGE:

Year

Months

Days

If less than one day

451

hrs.

min.

9. Birthplace

Drill, Va.

(Town, county, and state)

10. Usual occupation

Day laborer in Restaurant

11. Industry or business _____

MOTHER FATHER

12. Name

Paris Rowe

13. Birthplace

Virginia

14. Maiden name

Myrtle Sanders

15. Birthplace

Virginia

16. Informant

Mr. Fred Rowe

Address

Aberdeen, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

June 2, 19481948Nellie H. Riley

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 11948at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Cerebral ConcussionShock + HemorrhageDue to Compound fracture left leg+ fracture right leg

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide AccidentDate of June 1, 1948Where did injury occur? Aberdeen Harford MD
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) U.S. Rt. 40Means of injury Struck by truck Injured at work? no

23. SIGNATURE

J. H. Ramsey, M.D.Address Aberdeen Date signed 6/1/48

RECEIVED
JUN 8 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6241

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County HarfordCity or town Harve de Grace
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harve de Grace
(If outside city or town limits, write RURAL and give nearest town)Street No. Steege & Duval Highway
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

HOWARD H LYNCH

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mary Godfrey7. Birth date of deceased (mo., day, yr.) March 25, 1900 8. (a) If alive, give age 34 years8. AGE: Years 48 Months 2 Days If less than one day hrs. min.9. Birthplace Wilmington Del
(Town, county, and state)10. Usual occupation Salesman11. Industry or business Auto Accessories12. Name Phillip H. Lynch13. Birthplace Greenwood, Del14. Maiden name Clare Kerring15. Birthplace Greenwood, Del16. Informant Mrs. J. Gilbert HubbardAddress 304 West St Wilms Del17. Burial Date thereof 6-14-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory SilverbrookLocation Wilmington Del18. Funeral director Marshall & YeatmanAddress 819 Washington St. Wilms, DelJune 10 19 48 A.L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1948 at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death Carbon Monoxide Poisoning DURATIONSuicidal

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of death June 9, 1948Where did injury occur? Harve de Grace (City or town) Harford (County) Del (State)Injured at home, farm, industry, public place (where?) Tourist CourtMeans of injury Carbon Monoxide Injured at work? No23. SIGNATURE J. H. Ramsey M.D.Address Aberdeen, Md Date signed June 10, 1948

RECEIVED

JUN 12 1948

BUREAU V. S.

RECEIVED

JUN 15 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH

County Harford Co.City or town Harre Dr. Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred Harford Mem. Hosp.17 June 48 to 29 June 48

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania CountyCity or town Marietta
(If outside city or town limits, write RURAL and give nearest town)Street No. Market St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

HARRY T. MILLER

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

5 July 1880

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

671123

hrs.

min.

9. Birthplace

Marietta, Pa.
(Town, county, and state)

10. Usual occupation

Hardware Store operator

11. Industry or business

FATHER

12. Name

Osiah Muller

13. Birthplace

East Douglass Twp, Pa.

MOTHER

14. Maiden name

Fanny Hoerner

15. Birthplace

East Douglass Twp, Pa.

16. Informant

Ethelbert Muller

Address

Marietta, Pa.

17.

(Burial, cremation, or removal. Which?)

Date thereof

July 2 1948
(month) (day) (year)

Cemetery or crematory

Marietta, Pa.

Location

Marietta, Pa.

18. Funeral director

John L. Frey

Address

Marietta, Pa.

19.

(Date rec'd by registrar)

June 29 1948A. L. Lurio M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 June 1948 at 2:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

17 June 1948 to 29 June 1948and that I last saw him alive on 29 June 1948

Immediate cause of death

Gastric hemorrhage

DURATION

Due to

Carcinoma of esophagus and cardia of stomach

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Palliative gastrectomy
Metastatic carcinoma of stomach and regional nodes

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. J. Orment M.D.
Harre Dr. Grace Md Date signed 6-29-48

RECEIVED

JUL 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH: *Harford*
 County.....
 City or town..... *Bel Air*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *20 yrs*
 Hospital, institution, or street address where death occurred:
6 E. Broadway Ext.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... *Md.* County..... *Harford*
 City or town..... *Bel Air*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *6 E. Broadway Ext.*
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME *William Allen Miller*

3. (b) Social Security Number
213-01-6392

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*
 6. (b) Name of husband or wife *Myrtle Marie Miller*
 6. (c) If alive, give age *53* years
 7. Birth date of deceased (mo., day, yr.) *Apr. 13, 1893*
 8. AGE: Years *55* Months *2* Days *3* If less than one day
 hrs. min.

9. Birthplace..... *Balto. Md.*
 (Town, county, and state)
 10. Usual occupation..... *Salesman*
 11. Industry or business.....
 12. Name..... *Wm E. Miller*
 13. Birthplace..... *Calif.*
 14. Maiden name..... *Matilda Strom*
 15. Birthplace..... *Balto. Md.*

16. Informant..... *Mr. Myrtle Marie Miller*
 Address..... *6 E. Broadway Ext. Bel Air, Md.*
 17. Burial..... *Burial* Date thereof..... *June 18, 48*
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory..... *Bel Air Burial Park*
 Location..... *Bel Air, Md.*
 18. Funeral director..... *R. Madison Mitchell*
 Address..... *Laurel de Grace, Md.*
 19. *6/17* *48* *P. Lowwood*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *June 16* 19*48* at *12:05* A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19*25* June *48*
 and that I last saw him alive on *June 15* 19*48*
 Immediate cause of death..... *Myocardial failure*

Due to..... *Cardio-renal disease with hypertension - & anemia*
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?.....
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... *W. H. Miller* M. D. or other
 Address..... *Bel Air, Md.* Date signed..... *6/17/48*

RECEIVED

JUN 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH: Harford
 County Harford
 City or town Harford
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 days
 Hospital, institution, or street address where death occurred:
HARFORD MEMORIAL HOSPITAL
 How long in hospital or institution? 8 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Abersdeen Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 11 Baltimore St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

CHARLES BARNES MORGAN

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Unmarried
 6. (b) Name of husband or wife Etto Carcich
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) May 25 1874
 8. AGE: Years 74 Months _____ Days _____ If less than one day _____ hrs. _____ min.
 9. Birthplace Harford Co. Md
 (Town, county, and state)
 10. Usual occupation Carpenter
 11. Industry or business Unknown
 12. Name Unknown
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant Mr. Charles Curtis Morgan
 Address 11 Baltimore St. Abersdeen
 17. Burial Date thereof June 26 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Smiths Chapel
 Location Churchville Md
 18. Funeral director Henry Tarrington Sons
 Address Abersdeen Md
 19. June 24 1948 A. L. Lewis M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 JUNE 19 48 at 10:00 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 JUNE 19 48, to 22 JUNE 19 48
 and that I last saw him alive on 22 JUNE 19 48

Immediate cause of death RESPIRATORY FAILURE
 Due to CEREBRAL HEMORRHAGE
 Due to HYPERTENSIVE CARDIOVASCULAR DISEASE
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE P. B. Mornment M.D.
 Address Harford Md Date signed 6.22.48

Hoby

RECEIVED
JUN 26 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6245

Reg. Dist. No. 182

PLACE OF DEATH:

County HartfordCity or town Abersden Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HartfordCity or town Abersden Md
(If outside city or town limits, write RURAL and give nearest town)Street No. ✓
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ONEEDA Infant Plummer

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

36. (b) Name of husband or wife ✓

7. Birth date of deceased (mo., day, yr.)

June 29/486. (c) If alive, give age ✓ years

8. AGE:

Years

Months

Days

If less than one day

3

hrs.

min.

9. Birthplace

Abersden

(Town, county, and state)

10. Usual occupation ✓

11. Industry or business

FATHER
MOTHER

12. Name

Albert Wm Plummer

13. Birthplace

TENN.

14. Maiden name

Oneeda T Nelson

15. Birthplace

Va

16. Informant

Albert Wm Plummer

Address

Abersden, Md

17.

Burial
(Burial, cremation, or removal, Which?)

Date thereof

June 30/48
(month) (day) (year)

Cemetery or crematory

Mt Zion

Location

Fountain Green

18. Funeral director

Jos. T Foster

Address

Bellin Md

19.

6/29 1948
(Date rec'd by registrar)Jo Lowwood

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1948 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 29 1948

to

June 29 1948and that I last saw her alive on 6/29/48

Immediate cause of death

Prematurity

DURATION

3 1/2 hr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where)

Means of injury

Injured at work?

23. SIGNATURE

W. P. Rodman, M.D.
Abersden Md.

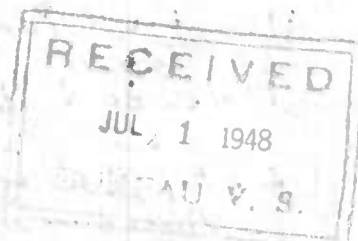
M. D. or other

Address

Date signed

6/29/48

Dr Rodman



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185

6246

930

1. PLACE OF DEATH:

County HarfordCity or town Havre de Grace, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 34 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)Street No. 550 Congress
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ellen T. Quirk

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow6. (b) Name of husband or wife Michael Quirk (dec.)7. Birth date of deceased (mo., day, yr.) July 28, 1877

6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
70 10 29 hrs. min.9. Birthplace Belcamp, Md.
(Town, county, and state)10. Usual occupation House wife

11. Industry or business

12. Name John Sullivan13. Birthplace Ireland14. Maiden name ?15. Birthplace Ireland16. Informant Elizabeth Quirk (daughter)Address 550 Congress St.17. Burial Date thereof 6/30/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. ErinLocation Havre de Grace, Md.16. Funeral director Pennington & SonAddress Havre de Grace, Md.18. June 30 19 48 G. L. Lewis M. D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sat June 26 19 48 at 2:30 P M21. CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 19 46 19 46 to June 26 19 48
and that I last saw him/her alive on June 26 19 48Immediate cause of death Acute myocarditis

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 9 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. J. Simon

M. D. or other

Address Havre de Grace Date signed June 29, 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County... *Harford*
 City or town... *Rural Bel Air Md.*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... *14 days*
 Hospital, institution, or street address where death occurred:
Harford Co. Nursing Home
 How long in hospital or institution?... *2 weeks*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... *Md.* County... *Harford*
 City or town... *Harred Grace Md.*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *420 N. Union Ave*
 (If rural, give LOCATION)
 2. (a) If veteran, name war...

3. (a) FULL NAME

LUCY HANNAH SCOTT

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced

8. (b) Name of husband or wife

unk.

7. Birth date of deceased (mo., day, yr.)

B. (c) If alive, give age... years

June 16, 1880

8. AGE:

Years 67

Months 11

Days 22

If less than one day

hrs. min.

9. Birthplace

Carroll Co. Md.

(Town, county, and state)

10. Usual occupation

House Duties

11. Industry or business

Home

FATHER

12. Name

John J. Freeman

13. Birthplace

Md.

MOTHER

14. Maiden name

Hannah Summons

15. Birthplace

Md.

16. Informant

Mrs. Bernice Freeman

Address 420 N. Union Ave. Harred Grace

17.

(Burial, cremation, or removal. Which?)

Date thereof

June 11, 1948

Cemetery or crematory

Kriders Cem.

Location

Carroll Co. Md.

18. Funeral director

R. Madison Mitchell

Address

Harred Grace, Md.

19.

(Date rec'd by registrar)

6/10 48 P. Towood

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... June 8 1948 at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 1948 to June 8 1948 and that I last saw him alive on June 8 1948

Immediate cause of death

LOBAR PNEUMONIA

DURATION

2 da.

Due to

Due to

Other conditions

CH. POSTERO-LATERAL SCLEROSIS OF SPINAL CORD

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

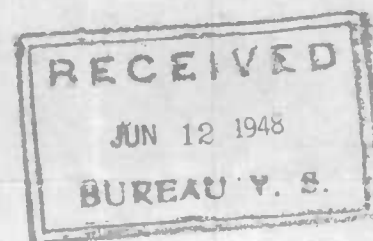
W. Seaward P. Hudson

M. D. or other

Address

Forest Hill Md.

Date signed 6/9/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County HarfordCity or town Harre de Grace
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5-9 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harre de Grace
(If outside city or town limits, write RURAL and give nearest town)Street No. 652 Orange St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JOSEPH BARRY (SEYFRIET)

3. (b) Social Security Number

717-07-57594. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married8. (b) Name of husband or wife Marie L. Seyfriet

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) 12/9/18888. AGE: Years 59 Months 6 Days 25 If less than one day..... hrs. min.9. Birthplace Harre de Grace
(Town, county, and state)10. Usual occupation Black Operator P.R.R.

11. Industry or business

12. Name Joseph Seyfriet13. Birthplace Germany14. Maiden name Roseline Thorpy15. Birthplace Ireland16. Informant Mr. Marie L. SeyfrietAddress 652 Orange St. Harre de Grace17. Buried Date thereof 6/9/48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Mt. ElmLocation Harre de Grace18. Funeral director Pennington & SonAddress Harre de Grace19. June 8 19 48 G. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 19 48 at 10:48 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death..... DURATION

Compound fracture of skull
Crushing injury of chestDue to.....
Compound fracture Rt. armDue to.....
ShoulderFracture Rt. leg & pelvis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: June 6, 1948Accident, suicide, or homicide Accident Date of June 6, 1948Where did injury occur Harre de Grace Harford md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) PRR BridgeMeans of injury Struck by train Injured at work? No23. SIGNATURE J. H. Ramsey, M.D.Address Aberdeen, md. Date signed June 6, 1948

RECEIVED

JUN 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6249

Reg. Dist. No. 182

1. PLACE OF DEATH:

County..... Harford
 City or town..... Bel Air Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 2 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Md County..... Harford
 City or town..... Bel Air Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Louis Shaffer

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... Single
 6.(b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.)..... April 18-1870 6.(c) If alive, give age..... years
 8. AGE: Years..... 78 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... Germany
 (Town, county, and state)
 10. Usual occupation..... Labore
 11. Industry or business.....
 FATHER 12. Name..... Louis Shaffer
 13. Birthplace..... Germany
 MOTHER 14. Maiden name..... Mary Miller
 15. Birthplace..... Beth, Md

16. Informant..... Clark J. Patrick
 Address..... Bel Air, Md
 17. Burial, cremation, or removal. Which?..... Burial Date thereof..... June 14/48
 (month) (day) (year)
 Cemetery or crematory..... Bel Air Rural Park
 Location..... Bel Air, Md
 18. Funeral director..... J. J. Fisher
 Address..... Bel Air, Md
 19. 6/13 48 P. Forwood
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 11 19..... 48 at..... 5:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 10 19..... 48 to..... June 11 19..... 48
 and that I last saw him..... alive on..... June 11 19..... 48

Immediate cause of death.....
Coronary Thrombosis DURATION..... 12 hours

Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... injured at work?

23. SIGNATURE..... Willard P. Hudson
 M. D. or other
 Address..... Forest Hill, Maryland Date signed..... 6/12/48

RECEIVED

JUN 17 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

184

6250

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH

County StarfordCity or town Donede Grace.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 minutesHospital, institution, or street address where death occurred: Starford MemorialHow long in hospital or institution? 20 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County CecilCity or town Principio Furnace
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2. (a) If veteran, name war World War 2. ✓

3. (a) FULL NAME

Norman Wesley Shinault

3. (b) Social Security Number

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) 9-8-1924 6. (c) If alive, give age _____ years8. AGE: Years 18 Months 9 Days 16 If less than one day _____ hrs. _____ min.9. Birthplace Donede Grace Ind.
(Give county, and state)10. Usual occupation attendant in day

11. Industry or business

12. Name Jesse M. Shinault13. Birthplace Cecil Co Ind.14. Maiden name Georgia E Cornett15. Birthplace Donede Grace Ind.16. Informant Jesse M. ShinaultAddress Perryville Ind.17. Burial Date thereof 6-26-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Principio MethodistLocation Principio M. Ayles18. Funeral director Joseph A. DavisAddress North East Ind.Date rec'd by registrar June 25-48 Registrar A. L. Lewis M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 19 48 12304

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Pneumonia & Pulmonary DURATION _____infection of rightDue to sepsis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

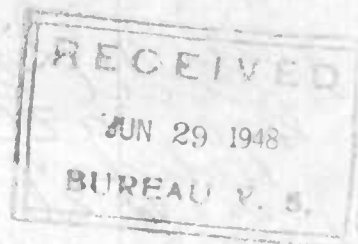
Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6/23-48Where did injury occur Principio Cecil Ind. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury 22 Caliber rifle Injured at work? noMedical Examiner Blk Dodson23. SIGNATURE Blk Dodson M. D. or other Cecil CountyAddress Principio Ind. Date signed 6/24-48



Evidence for change of
birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6251

Reg. No. G 116 JUN 28 1948

CERTIFICATE OF DEATH

Reg. Diat. No. 181

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal)

Cemetery or crematory

Location

18. Funeral director

Address

19. June 7 1948 (Date rec'd by registrar)

20. B. Knight Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other conditions

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

23. SIGNATURE

Address

M. D. or other

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 22 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6252

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford Rural
City or town Belt air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, institution or street address where death occurred:
County Home
How long in hospital or institution? 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Harford
City or town Rural - Belt air
(If outside city or town limits, write RURAL and give nearest town)
Street No. elmshouse
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

John Henry Singleton

3. (b) Social Security Number

4. Sex male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife Annie Hopkins Singleton

7. Birth date of deceased (mo., day, yr.) Oct. 10 1952 6.(c) If alive, give age..... years

8. AGE: Years 95 Months 8 Days 3 If less than one day..... hrs. min.

9. Birthplace Harford Co. Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name John Singleton 13. Birthplace Harford Co. Md.

MOTHER 14. Maiden name Mary Mubury 15. Birthplace Harford Co. Md.

16. Informant Mrs. Mabel Hopkins

Address Cardiff, Md.

17. Burial, cremation, or removal, Which? June 15, 1948
(month) (day) (year)

Cemetery State Ridge
Location Delta, Pa.

18. Funeral director Hubert R. Harkins
Address Delta, Pa.

19. 6/13 48 Forest Hill
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1948 at 12:00 Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1948 to June 13 1948 and that I last saw him alive on June 13 1948

Immediate cause of death Lobar pneumonia DURATION 3.00

Due to.....

Due to.....

Other conditions ch. myocardial
degenerate
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Willard P. Hudson M. D. or other
Address Forest Hill Md Date signed 6-13-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:

County HARFORD
 City or town ARMY CHEMICAL CENTER EDGEMOND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 16 MOS.
 Hospital, institution, or street address where death occurred:
QUARTERS #312
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Army Chemical Center
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Edgemoor Rd
 (If rural, give LOCATION)
 2.(a) If veteran, name war —

3. (a) FULL NAME

RHODA MAE SULLIVAN

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced WIDOWED
 6.(b) Name of husband or wife Franc Sullivan
 7. Birth date of deceased (mo., day, yr.) Dec. 7, 1894 6.(c) If alive, give age — years
 8. AGE: Years 53 Months 6 Days 5 If less than one day — hrs. — min.

9. Birthplace Newfoundland
 (Town, county, and state)
 10. Usual occupation Nurse
 11. Industry or business —

12. Name William Gollage
 13. Birthplace France
 14. Maiden name Eileen Gollage
 15. Birthplace England
 16. Informant Sgt Donald Coombston
 Address Army Chemical Center Md
 17. Buried Date thereof Jan 15, 1948
 (Burial, cremation, or removal) Which? (month) (day) (year)
 Cemetery or crematory Post Cemetery
 Location Army Chemical Center, Md
 18. Funeral director Harold K. McCombs Son
 Address Chesapeake Maryland
 19. June 15 19 48 Manuel M. Mable
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/12 19 48 at 6 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/12 19 48 to 6/12 19 48
 and that I last saw him FR alive on 6/7 19 48
 Immediate cause of death CONGESTIVE HEART FAILURE, PULMONARY EDEMA DURATION 1 MO.
 Due to GENERALIZED CARCINOMA-TOSIS
 Due to CARCINOMA OF CERVIX OF UTERUS
 Other conditions —
 (Include pregnancy within 8 months of death)

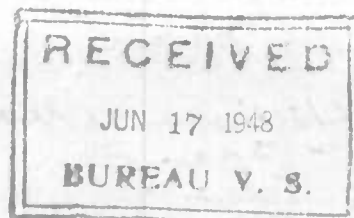
Major findings of operations — Date of op. —

Autopsy results —
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide — Date of —
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE C. W. Stewart Jr. M.D. M. D. or other
 Address EDGEWOOD, MD. Date signed 6/12/48

34



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:

County HarfordCity or town Laurel Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hosp.

How long in hospital or institution?

4 hrs 15 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County HarfordCity or town Charles M
(If outside city or town limits, write RURAL and give nearest town)Street No. Edmond
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

BOBBY BOY THOMAS

3. (b) Social Security Number

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 29 - 1948

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

4 hrs.15 min.

9. Birthplace

Harford, Md
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

MOTHER FATHER

12. Name

Leota Thomas

13. Birthplace

Ind

14. Maiden name

Walter Curry

15. Birthplace

Ind

16. Informant

Leota Thomas

Address

Edmond Ind

17.

(Burial, cremation, or removal, Which?)

Date thereof

July 1 - 1948
(month) (day) (year)

Cemetery or crematory

Walter Curry

Location

Charles M

18. Funeral director

Nancy Fanning Long

Address

Edmond Ind

19.

(Date rec'd by registrar)

June 29 1948 A.L. Lewis M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

29 June 1948 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

29 June 1948 to 29 June 1948and that I last saw him alive on 29 June 1948

Immediate cause of death

Respiratory failure

DURATION

Due to

Fetal atelectasis

Due to

Prematurity

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

AB/Priment M

M. D. or other

Address Laurel Grace Ind Date signed 29 June 48

RECEIVED

JUL 3 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6255

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County Harford
City or town Harford de France
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Harford Memorial
How long in hospital or institution? 3 1/2 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Cecil
City or town North East
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war. _____

3. (a) FULL NAME

Josephine C. Ward

3. (b) Social Security Number

220-14-9789

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Joseph P. Ward
6. (c) If alive, give age 48 years
7. Birth date of deceased (mo., day, yr.) March 28 1899
8. AGE: Years 49 Months _____ Days _____ It less than one day _____ hrs. _____ min.

9. Birthplace Calvert, Cecil Co Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Charles R. Chapman

13. Birthplace Nottingham Perry

14. Maiden name Christiane Bowsbly

15. Birthplace Maryland Penna

16. Informant Joseph P. Ward

Address North East Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof June 12 1948
(month) (day) (year)

Cemetery or crematory Friends

Location Calvert Md

18. Funeral director Joseph R. Evans

Address North East Md

Date June 11 48 G. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 June 1948 at 12:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 June 1948 to 10 June 1948

and that I last saw him/her alive on 10 June 1948

Immediate cause of death Shock

Due to Acute Gastric Dilatation

Other conditions Essential Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations Torted 6 lb R. ovarian Cyst. Date of op. 8 June 48

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W.H. Sadowsky M.D. M. D. or other _____

Address Perryville Md Date signed 10 June 48

(Date rec'd by Registrar)

Registrar

Address

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 14 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County HarfordCity or town Burial Bel Air
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

3 weeks

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Chesden Md
(If outside city or town limits, write RURAL and give nearest town)Street No. Stoney
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Noble Ward

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Unknown

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) (Unknown) 1880

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

About 68

..... hrs. min.

9. Birthplace

Charles Co
(Town, county, and state)

10. Usual occupation

Day Laborer

11. Industry or business

Unknown

MOTHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 - 1948 at 12 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 26 48 to June 28 48
and that I last saw h. in alive on June 26 1948

Immediate cause of death

Arteriosclerotic C.V.
disease

DURATION

6 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Gerald C Palmer M.D.

M. D. or other

Address

Bel Air, Md.Date signed 6/28/48

1880

89

1948

RECEIVED

JUL 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and correctly. Write the correct age is especially important. Physicians: please write the causes of death clearly and accurately.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 185-

1. PLACE OF DEATH

County Harford
 City or town Havre de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 hrs 5 minutes
 Hospital, institution, or street address where death occurred:
Harford Memorial
 How long in hospital or institution? 5 hrs 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State md County Cecil
 City or town Principia Furnace
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION) _____
 2.(a) If veteran, name war _____

3. (a) FULL NAME

VIRGINIA LEE
BABY GIRL WARRINGTON

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced INFANT

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 5 1948
 8. AGE: Years _____ Months _____ Days _____ It less than one day 5 hrs. 5 min.

9. Birthplace Havre de Grace, md
 (Town, county, and state)

10. Usual occupation none

11. Industry or business _____

12. Name John W. Warrington

13. Birthplace Elkton Rural, Md

14. Maiden name Virginia Lee Hartman

15. Birthplace Gumbelund, md

16. Informant John W. Warrington

Address Principia Furnace, md

17. (Burial, cremation, or removal. Which?) Burial Date thereof 6-7-48
 (month) (day) (year)

Cemetary or crematory Methodist

Location NorthEast, md

18. Funeral director Joseph H. Frank

Address NorthEast, md

19. June 5 48 20. A. L. Lewis m. d.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 June 1948, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____ to _____ 19____

and that I last saw her alive on 5 June 48

Immediate cause of death Respiratory failure DURATION _____

Due to Fetal atelectasis _____

Due to Prematurity _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE R. B. Norman M.D.

Address Harford Memorial Hosp Date signed 6-5-48

RECEIVED

JUN 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6258

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford
City or town Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs. 6 mos.
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Harford
City or town Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Daniel Dudley Waters

3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Mary S. Masteller
6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) August 2, 1853

8. AGE: Years 94 Months 10 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Pleasantville Harford Co. Md.
(Town, county, and state)

10. Usual occupation Blacksmith

11. Industry or business _____

12. Name Waters

13. Birthplace Harford Co. Md.

14. Maiden name Ellen Waters

15. Birthplace Harford Co. Md.

16. Informant Mrs. Mary Nevo Coleman

Address Forest Hill, Md.

17. Burial Date thereof June 24 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematorium Mt Zion

Location Near Bel Air

18. Funeral director Henry Tarrington & Sons

Address 10000 Deerfield Rd.

19. 6/23 48 10 Forest Hill
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 21, 1948 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOVEMBER 2, 1947 to JUNE 21, 1948

and that I last saw him alive on JUNE 21, 1948

Immediate cause of death SENILITY

DURATION 2 YRS.

Due to _____

Due to _____

Other conditions CEREBRAL ARTERIOSCLEROSIS 10 YRS.

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert Barthel MD

Address Forest Hill Md Date signed 6/22/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 25 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford
City or town Lawrenceville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Harford Memorial
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Cecil
City or town Port Deposit, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

PATRICIA JUNE Willen

3. (b) Social Security Number

4. Sex F 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 25, 48 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
17 hrs. 20 min.

9. Birthplace Lawrenceville, Harford, Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Ray Willen
13. Birthplace West Va.
14. Maiden name Creek Armstrong
15. Birthplace West Virginia

16. Informant Ray Willen
Address Port Deposit, Md Rural

17. Burial Date thereof June 27, 1948
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematorium West Nottingham
Location Colona, Md. Rural

18. Funeral director Lee A. Patterson & Son
Address Perryville, Md.

Date rec'd by registrar June 27, 1948 Registrar G. L. Lewis M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 June 48 9:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 June 48 to 26 June 48 and that I last saw him alive on 26 June 48

Immediate cause of death Respiratory failure DURATION

Due to Brain stem damage

Due to Cerebral anoxia before delivery

Other conditions Placental separation and placenta with concealed hemorrhage in mother.
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. P. Marmont M.D.
Address Lawrenceville, Md Date signed 6-26-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4606.

RECEIVED
JUN 29 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

6260

181

185-

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal (where))

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. July 1, 48

(Date rec'd by registrar)

19. 48

A. L. Lewis M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

30 June 48

19. 48

at 11

30

A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

29 June 48

19. 48

to 30 June 48

19. 48

and that I last saw her alive on

30 June 48

19. 48

Immediate cause of death

Shock + toxemia

DURATION

Due to

2nd° burns of 75% of body

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Accident

Date of

29 June 48

Where did injury occur?

Baltimore Md.

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Home

Means of injury

Burn

Injured at work?

23. SIGNATURE

R. J. Norman M.D.

M. D. or other

Address

Havre de Grace Md.

Date signed 6:30-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1881
69
1946

